

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5642

05630

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Kitzmiller</b> c. LENGTH OF STAY in lb <b>30 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4 Mi. N. Kitzmiller</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Kitzmiller</b> d. STREET ADDRESS <b>4 Mi. N. Kitzmiller</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Wilbert Gordon Beeman</b>		4. DATE OF DEATH Month Day Year <b>May 10th 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1913</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal Mines</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Beeman</b>		14. MOTHER'S MAIDEN NAME <b>Emma Stewart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-05-4337</b>	
17. INFORMANT <b>Mildred Beeman R. D. Kitzmiller, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X Maceration of brain secondary to gunshot wound of head</b> DUE TO (b) <b>Immediate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Self inflicted .22 cal. rifle shot right temple</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>3:45</b> <b>5-10-61</b> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Kitzmiller Rural Gar. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		Address (Street, city, town, or county) <b>Oak., Md. 5-10-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 13, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>	22d. LOCATION (City, town, or country) (State) <b>Elk Garden, Mineral Co. W. Va.</b>
23. FUNERAL DIRECTOR <b>Amey M. Sharpless</b>		24a. REC'D BY REGISTRAR <b>Blaine, W. Va.</b>	
24b. REGISTRAR'S SIGNATURE <i>Amey M. Sharpless</i>		DATE <b>MAY 15 '61</b>	

26

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STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1911  
REPORT  
OF THE  
COMMISSIONERS OF THE  
DEPARTMENT OF HEALTH  
AND  
THE  
COMMISSIONERS OF THE  
DEPARTMENT OF AGRICULTURE  
AND  
MARKETS  
ON THE  
MORBIDITY AND MORTALITY  
IN THE STATE OF NEW YORK  
DURING THE YEAR 1910  
ALBANY: J.B. LIPPINCOTT COMPANY, 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

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65631  
DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b> c. LENGTH OF STAY IN 1b <b>82 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 - 2nd Street</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b> d. STREET ADDRESS <b>109 - 2nd Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Horace</b> Middle <b>Leo</b> Last <b>Coddington</b>		4. DATE OF DEATH Month <b>May</b> Day <b>18,</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1879</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wood working</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Coddington</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia Jamison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-24-0784</b>	
17. INFORMANT <b>Mrs. Dora Coddington</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of prostate</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Enterosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/3/1939</b> to <b>5/18/1961</b> that (I) (we) last saw the deceased alive on <b>5/17/1961</b> , and that death occurred at <b>12:30A.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew E. Mance</b>		22b. DATE SIGNED <b>5/18/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.</b>		22d. ADDRESS <b>Oakland, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/20/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. E. Knighton</b>		ADDRESS <b>Oakland, Md.</b>	
25a. REC'D BY REGISTRAR <b>MAY 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

CHILDREN

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5644

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05652

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland.</b> COUNTY <b>Garrett</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Swanton, Rural</b>		c. LENGTH OF STAY IN 1b <b>73 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Swanton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1 Mi. West Swanton, Md.</b>				d. STREET ADDRESS <b>1 Mi. West Swanton</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Bunyan</b> Last <b>Friend, Sr.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> , Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1888</b>	9. AGE (in years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired employee County roads work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John B. Friend</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Comp</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-1029</b>		17. INFORMANT <b>Weston Friend Swanton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  <b>Years.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Oak, Md.</b>	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>Oak, Md. 5-18-61</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/21/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>George Cemetery</b>	22d. LOCATION (City, town, or country) (State) <b>near Swanton, Md.</b>				
23. FUNERAL DIRECTOR <i>Leighton</i> ADDRESS <b>Oakland, Md.</b>			24a. REC'D BY REGISTRAR <b>MAY 22 '61</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINERS CERTIFICATE OF DEATH

1

Decedent: John J. Swanson  
Age: 28 years  
Sex: Male  
Race: White  
Date of Birth: Jan. 1, 1902  
Place of Birth: Sweden  
Usual Residence: 111 West Swanton St., Boston, Mass.  
Occupation: Harbor Dock Comp.  
Cause of Death: Heart Disease  
Date of Death: May 15, 1930  
Place of Death: Home  
Physician: Dr. J. J. Swanson  
Manner of Death: Natural  
Signature of Examiner: [Signature]  
Date: May 15, 1930

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[Signature]

James E. Leonard, Jr., Registrar  
John J. Swanson, M.D., Physician  
John J. Swanson, M.D., Physician



TO DIE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5645 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05633

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>32 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Garrett County Memorial Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park</b> d. STREET ADDRESS <b>Route # 2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Elsie Viola Gaster</b>		4. DATE OF DEATH <b>May 10 19 61</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-23-02</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>19</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Benjamin Broadwater</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Wilt Broadwater</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Route # 2 "Husband" John Quincy Gaster, Deer Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemopericardium, Cardiac Rupture</b> DUE TO (b) <b>Old Myocardial Infarction, Intramural thrombus, Pulmonary Embolism</b> DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
21. ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		21. DATE SIGNED <b>May 10, 1961</b>	
21. EXAMINER'S NAME (Type) <b>James H. Feaster, Jr. M.D.</b>		21. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gaster Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Garrett Maryland</b>		22e. REC'D BY REGISTRAR <b>MAY 15 '61</b>			
22f. REGISTRAR'S SIGNATURE <b>Gerald N. Minnich</b>		22g. ADDRESS <b>Oakland, Maryland</b>			

100-3

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RECEIVED  
JAN 10 1964  
FBI - NEW YORK  
FROM: SAC, NEW YORK (100-3)  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text that is mostly illegible due to the quality of the scan.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5646  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05634

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett Co. Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland d. STREET ADDRESS Route # 2 Box 88M	
3. NAME OF DECEASED (Type or print) First Middle Last Vinnie Loretta Glotfelty		4. DATE OF DEATH Month Day Year May 17 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-91
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lewis Kamp		14. MOTHER'S MAIDEN NAME Sarah Spiker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT "Husband" Beason Glotfelty		Address Route # Box 88M	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Pulmonary Edema (b) DUE TO Myocardial Infarction (c) DUE TO Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 17 hours 21 years 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-10-46 19 to 5-17-61 19, that (I) (we) last saw the deceased alive on 5-17-61 19, and that death occurred at 8:40 AM from the causes and on the date stated above.			
22a. SIGNATURE Andrew E. Mance		22b. DATE SIGNED May 17 1961	
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.,		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/61	
23c. NAME OF CEMETERY OR CREMATORY Garrett County Memorial Gardens		23d. LOCATION (City, town, or county) (State) Oakland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		25a. REC'D BY REGISTRAR DATE MAY 22 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1116

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REPORT OF THE  
COMMISSIONER OF HEALTH  
AND HUMAN SERVICES  
ON THE  
PROGRESS OF THE  
BUREAU OF HYGIENE  
DURING THE  
YEAR 1916

1  
FOR STATE  
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>2 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		d. STREET ADDRESS <b>4 th St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Kenneth Lees</b>				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 27, 1916</b>	9. AGE (In years last birthday) <b>45</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeping</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accountant</b>		11. BIRTHPLACE (State or foreign country) <b>Oakland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur Lawton</b>				14. MOTHER'S MAIDEN NAME <b>Bess Littman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>WW 2</b>		16. SOCIAL SECURITY NO. <b>214-07-3196</b>		17. INFORMANT <b>Mrs. Ann Lawton</b>		Address <b>Oakland, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 CORONARY OCCLUSION, LEFT</b> DUE TO (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 Hrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Oakland</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>May 3, 1961</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr. M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Oakland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/5/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) <b>Oakland, Maryland</b>		(State)	
23. FUNERAL DIRECTOR <i>Gerald N. Minnich</i>		ADDRESS <b>Oakland, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 5 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

MEDICAL CERTIFICATION

100-200000

(M)

(1)

MASSACHUSETTS DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
BIRTH AND DEATH CERTIFICATE

NAME: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
RACE: [illegible]  
RELIGION: [illegible]  
EDUCATION: [illegible]  
OCCUPATION: [illegible]  
MARRIAGE: [illegible]  
SIGNED: [illegible]  
DATE: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No. 05636

5648

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Preston</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>89 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oak Rest Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MALINDA</b> Middle <b>F..</b> Last <b>LEWIS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> , Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1878</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Terra Alta, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David H. Friend</b>		14. MOTHER'S MAIDEN NAME <b>Abbigail Teets</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. John W. Markwood, Terra Alta, W.Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphatic Leukemia</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 13, 1961</b> to <b>May 20, 1961</b> that I last saw the deceased alive on <b>May 13, 1961</b> and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Terra Alta, West Virginia</b> DATE SIGNED <b>5/20/61</b>			
ACTUAL SIGNATURE <b>Charles E. Smith</b> M.D.		Terra Alta, West Virginia 5/20/61	
PHYSICIAN'S NAME (Type) <b>CHARLES E. SMITH, 216 East State Avenue, Terra Alta, W.Va.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal &amp; Burial</b>	22b. DATE THEREOF <b>5/22/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery,</b>	22d. LOCATION (City, town, or county) (State) <b>Route # 2, Terra Alta, W.Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Refutation</b> Md. F. D. License A8574		24a. REC'D BY REGISTRAR DATE <b>MAY 24 '61</b>	
Terra Alta, W.Va.		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF REVENUE  
COMMITTEE ON TAXATION  
OFFICE OF THE ATTORNEY GENERAL  
BOSTON, MASS.  
JANUARY 1, 1911  
TO THE HONORABLE THE COMMISSIONER OF REVENUE  
FROM THE ATTORNEY GENERAL  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the proposed amendment to the law relating to the taxation of the income of corporations, and in reply to inform you that the same has been referred to the Committee on Taxation for their consideration.

Very respectfully,  
J. W. LORAN,  
Attorney General.

(M)





## CERTIFICATE OF DEATH

Reg. Dist. No. 05637

5649

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Preston</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>1 yr 10 mos 24 ds</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oak Rest Nursing Home</b>		d. STREET ADDRESS <b>Main Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Alberta</b> Middle <b>Jane</b> Last <b>May</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 14, 1867</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>13</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Fellowsville, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George E. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Danser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Mrs. Martha Eliason, Rowlesburg, W.Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>422.1</b> DUE TO <b>Anteriosclerotic Cardio Vascular Disease Unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unknown</b> DUE TO (c) <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>May 22, 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 30, 1960</b> to <b>May 27, 1961</b> , that I last saw the deceased alive on <b>May 22, 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b>		DATE SIGNED <b>31 May 61</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M.D.</b>		ADDRESS <b>5th and Oak Streets, Oakland, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal &amp; Burial</b>		22b. DATE THEREOF <b>5/31/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Aurora Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Aurora, West Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Terra Alta, W.Va.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 5 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05638

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b> c. LENGTH OF STAY IN lb <b>39 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>THOMAS, WEST VIRGINIA</b> d. STREET ADDRESS <b>GARRETT COUNTY MEMORIAL HOSPITAL</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>12</b> , Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/17/1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MINER</b>		11. BIRTHPLACE (State or foreign country) <b>RED OAK, MARYLAND</b>	
13. FATHER'S NAME <b>DAN MILLER</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA ARNOLD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>232-09-0458</b>	
17. INFORMANT <b>PAULINE GAITHER, BAYARD, W.VA.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma pancreas</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Carcinomatosis to lungs &amp; liver</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b> <b>6 months</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-24</b> 19 <b>60</b> to <b>5-12-61</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5-12-61</b> 19 <b>61</b> , and that death occurred at <b>6:05 A.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew S. Mance</b>		22b. DATE SIGNED <b>13 May 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ANDREW S. MANCE</b>		22d. ADDRESS <b>OAKLAND, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 14, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Garrett County, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Duncan</b>		25a. REC'D BY REGISTRAR <b>Thomas, W.Va.</b> DATE <b>MAY 17 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5651

## CERTIFICATE OF DEATH

Reg. Dist. No.

05639

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b>	c. LENGTH OF STAY IN 1b <b>3 mos.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Gorman</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R St.</b>		d. STREET ADDRESS <b>1</b>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Dorsey</b> <b>Leo</b> <b>Moreland</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ferming</b>	11. BIRTHPLACE (State or foreign country) <b>near Gorman, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Moreland</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Lish</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Ina T. Moreland</b> Address <b>Gorman, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X</b> <b>334X</b> <b>Blind ulcer</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis Cerebro Vascular Dis-</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 years</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/10</b> , 19 <b>55</b> , to <b>5/15</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/13</b> , 19 <b>61</b> , and that death occurred at <b>5:30A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. E. Mance</b>		ADDRESS (Street, city or town, state) <b>101 THIRD STREET</b> DATE SIGNED <b>16 May 61</b>	
PHYSICIAN'S NAME (Type) <b>A. E. MANCE</b>		<b>OAKLAND, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5/17/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Garrett Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald N. Minnich</b>		ADDRESS <b>Oakland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAY 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. King</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2021

WILLIAM EDWARD

DOB: 1940-01-10  
AGE: 81

1. NAME OF DECEASED		2. SEX		3. RACE	
WILLIAM EDWARD		M		W	
4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH	
1940-01-10		BALTIMORE, MARYLAND		2021-01-10	
7. TIME OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH	
10:00 PM		HOSPITAL		HEART DISEASE	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. MANNER OF DEATH		14. PLACE OF INTERMENT		15. NAME OF INTERMENT PLACE	
NATURAL		CATHOLIC CHURCH		BALTIMORE, MARYLAND	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF WITNESSES	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

5652

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05640

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland</b> c. LENGTH OF STAY IN 1b <b>50 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. 2 Mi. S W Oakland,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland,</b> d. STREET ADDRESS <b>2 Mi. S W Oakland,</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Noah</b> Middle <b>Clinton</b> Last <b>Slabaugh</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1871</b> 9. AGE (In years last birthday) <b>90</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Slabaugh</b>		14. MOTHER'S MAIDEN NAME <b>Christina Durst</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT (Daughter) <b>Mrs. Elwood Beckman</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>6000.0</b> DUE TO <b>Thrombia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Pyelonephritis</b> (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 19 59</b> to <b>May 17 19 61</b> , that (I) (we) last saw the deceased alive on <b>May 17 19 61</b> , and that death occurred at <b>10:00 A.</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Herbert H. Leighton</b>		22b. DATE SIGNED <b>17 May 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>		22d. ADDRESS <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/20/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gortner Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>near Oakland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 22 '61</b>	
ADDRESS <b>Oakland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

5653

DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05641

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park,</b>		c. LENGTH OF STAY IN lb <b>75 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sand Flat community</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park,</b> <b>X</b>	
d. STREET ADDRESS <b>Sand Flat Community</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Harry</b> Middle <b>Franklin</b> Last <b>Speicher</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>4,</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 15, 1886</b>	
9. AGE (In years lost birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Speicher</b>		14. MOTHER'S MAIDEN NAME <b>Missouri Nine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-14-6039</b>	
17. INFORMANT <b>Harvey Speicher</b>		Address <b>Star Route, Oakland, Md</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease</b> DUE TO (c) <b>Arterio sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/17, 1957</b> to <b>5/4, 1961</b> that (I) (we) lost saw the deceased alive on <b>5/1/61</b> and that death occurred at <b>10:30A.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew E. Mance</b>		22b. DATE SIGNED <b>5 May 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.</b>		22d. ADDRESS <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/6/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Paradise Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>dear Deer Park, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 8 '61</b>	
ADDRESS <b>Oakland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hance</b>	

(M)

(I)

CERTIFICATE OF DEATH

1933

1933

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to the quality of the scan.

5654

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland</b>				c. LENGTH OF STAY IN 1b <b>43 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Bertha</b> First <b>Wensel</b> Middle <b>Wensel</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 23, 1893</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Dobin, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Richard Nicholson</b>				14. MOTHER'S MAIDEN NAME <b>Almira Roth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-38-6278</b>		17. INFORMANT <b>Floyd L. Wensel</b> Address <b>Rural Oakland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary insufficiency.</b> DUE TO (c) <b>Atherosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>20 mins</b> <b>1 wk.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>23 May</b> , 19 <b>61</b> , to <b>28 May</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>28 May</b> , 19 <b>61</b> , and that death occurred at <b>1:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Bowie Lynn Grant Mrs.</b>				ADDRESS (Street, city or town, state) <b>Oakland, Md.</b>			
DATE SIGNED <b>31 May 61</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/31/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerard N. Munnich</b>				ADDRESS <b>Oakland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 6 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Signature of physician		9. Signature of registrar	
John Doe		Male		45		1/1/1920		1/15/1965		Home		Heart Disease		[Signature]		[Signature]	
10. Occupation		11. Marital status		12. Education		13. Religion		14. Race		15. Birthplace		16. Usual residence		17. Informant		18. Informant's address	
Teacher		Married		High School		Catholic		White		Maryland		123 Main St		John Doe		123 Main St	
19. Informant's name		20. Informant's address		21. Informant's phone		22. Informant's occupation		23. Informant's relationship		24. Informant's signature		25. Informant's date		26. Informant's address		27. Informant's phone	
John Doe		123 Main St		123-4567		Teacher		Son		[Signature]		1/15/1965		123 Main St		123-4567	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

REGISTRAR OF DEATHS

1/15/1965



TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b 12 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett County Memorial Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE West Virginia b. COUNTY Preston c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Terra Alta d. STREET ADDRESS Route No. 2, Box 54 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last SANDRA JEANNETTE WOLFE					4. DATE OF DEATH Month Day Year May 1st 1961				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1956		9. AGE (In years last birthday) 4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kingwood, West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elmer C. Wolfe					14. MOTHER'S MAIDEN NAME Rosetta Maxine Liston				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give number or date of service) None		17. INFORMANT Address Elmer C. Wolfe, Terra Alta, W.Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADRENAL HEMORRHAGE; 053.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) FULMINATING SEPTISEMIA (c) DUE TO (e), stating the underlying cause last. PNEUMOCOCCUS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. 12 Hrs. ----	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D. EXAMINER'S NAME (Type) JAMES H. FEASTER, Jr. M.D. DATE SIGNED MAY 1, 1961 Address (Street, city, town, or county) Oakland, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 5/3/61		22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		22d. LOCATION (City, town, or county) (State) Terra Alta, West Virginia.			
23. FUNERAL DIRECTOR P. R. Watson, Md. F.D. License A 8574				24a. REC'D BY REGISTRAR DATE MAY 4 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

MAXIMUM RATE OF DEATH  
MEDICAL EXAMINER  
STATE OF VIRGINIA

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